



**DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420**

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June 29, 1999

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

NATIONAL CENTER FOR PATIENT SAFETY

1. Untoward outcomes for patients consequent to their medical care is a worldwide problem that has been identified and discussed in the literature and elsewhere for decades. In order to address this problem, the Veterans Health Administration (VHA) has formed the National Center for Patient Safety (NCPS – pronounced N-sips).
2. NCPS has been established to develop, lead and/or oversee activities and programs concerned with improving patient safety. Specifically, the NCPS will work to measure, develop, and implement methods that minimize the chance of untoward outcomes consequent to medical care. The Center will employ a systems approach that emphasizes error prevention as the preferred method to accomplish this goal. For this effort to be effective, it will be necessary to establish methods of gathering and analyzing accurate and reliable data from the field that will lead to prudent solutions to identified problems.
3. To be successful, it will be necessary to develop and carefully nurture a culture of safety at VHA facilities. This requires focused attention. The writing of directives and the provision of training are not sufficient by themselves to create an environment where all employees, and even patients, each personally view safety as their highest priority. A proactive approach to making the entire system safer is not just a nice thing to do, but rather it is the only way to do business. To accomplish this, the NCPS will identify, plan, test, and implement programs aimed at ensuring that safety is viewed as a continuum throughout the organization; encompassing staff, trainees, patients, and visitors.
4. The NCPS will first develop techniques and methods that allow the collection and analysis of relevant data, from sources within and outside the VA, which will facilitate the identification and understanding of areas of concern. Armed with this information the NCPS will propose and initiate interventions ranging from providing feedback directly to the concerned parties and recommending corrective actions that should be effective, to engaging in further research to better understand the issues prior to defining actions. In all of these activities the NCPS will need to work closely with a number of other intra- and extra-mural organizations to ensure that the most desirable outcomes can be realized.
5. The NCPS will assist the Under Secretary for Health in providing direction and guidance to other activities that play a role in patient safety, including, but not limited to, the Patient Safety Oversight Committee and the Patient Safety Centers of Inquiry. Additionally, the NCPS will develop policies and procedures aimed at the improvement of patient safety and be active in the management of their implementation at the direction of the Under Secretary for Health.

6. To maximize the positive impact and utility of these efforts, the NCPS will also develop and implement education and training activities. These will be aimed at a wide audience, ranging from the professional care providers and patients, to other VHA stakeholders, including the public and Congress. It is anticipated that along with significant improvements in patient outcome, the work done by the NCPS will be of value to numerous agencies and industries interested in a systems approach to making their activities safer and creating a culture of safety.

7. Questions should be directed to James Bagian, M.D., Director, National Center for Patient Safety, at 734-761-7665.

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Under Secretary for Health

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